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The Colostomy Association
0800 587 6744

CUI Wear
Underwear + Swimwear for ostomists
0800 279 2050 Quote Ref IOU256

Want to join the support group?

If you have a colostomy, ileostomy or a urostomy and you would like more information, please complete the form below an send it to: Sarah Varma c/o Stoma Care Department, St Mark's & Northwick Park Hospital, Watford Road, Harrow, Middlesex, HA1 3UJ

Name _____

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_____

Postcode _____ Telephone _____

Annual membership subscription £5.00. Cheques payable to "St Mark's Hospital Foundation (Inside Out)
Diane Owen, 170 Malvern Avenue, Harrow, Middlesex, HA2 9HD

Spring 2009 Newsletter

INSIDE OUT

Volume 3 Issue 9

STOMA SUPPORT GROUP WORKING WITH ST. MARKS AND NORTHWICK PARK HOSPITAL
Incorporated with St. Mark's Hospital Foundation Charity Registration No. 1088119

Bob's Hello!

Dear Friends,

Yes, it's that time again where we try to bring you up to date with what has been going on with our group and with any new developments that may be of interest to you.
I have to start with some sad news - in the past few months some of our Ostomy friends have passed away; Joan Hollister, Winifred Cottrell and Alexandra Homatas. Our thoughts and our prayers go out to their family and friends. We will remember them for the humour and friendship they brought to us whenever we were in their company.
A number of companies have come out with new products. For those of you who have dexterity problems, Salts have produced a product called Harmony Duo, two-piece and the easiest way to explain how it works is it is similar to a Velcro action. Dansac, have brought their own flushable two piece closed bag out which if you go into their website www.dansac.com they give you an informative video guide on how to take it apart and dispose of it, plus all factual information on the product. Ostomart have come up with a new fragrance to add to their collection of Ostomist odour neutralisers, Cinnamon & Sandalwood. CliniMed Freestyle range also has a new product called Vie for both closed and drainable. All of these products are available from Fittleworth as free samples. Department of Health's Live Consultations are finally over after three years of backward and forwarding of letters, from ostomists up and down the UK, to their MP's and support groups like ours making loud noises at meetings with the DHS that they finally have taken on board our needs so that we may have a better quality of life. The manufacturers and Pharmacists who provide the appliances and services have accepted the findings which in theory will come into operation on 1st January 2009. We will of course keep you up to date with any developments in this matter as it is very relevant to our quality of life.

Best Wishes to you all,
Bob

Hi there fellow ostomists,

It doesn't seem a year ago that I was wishing you all every best wish for 2008, and now we're in 2009! Where does the time go? I hope that 2008 was a good year for you, if not; I hope 2009 will be a lot better.

What can I say in this first missive of the New Year? New Year to me means membership is due! It is only £5.00 a year and worth every penny. If you have a standing order set up – thank you. If you would like to set up a standing order, let me know and I will send you a form. I wouldn't mind receiving a cheque but preferably not cash. I wait, in anticipation, for the post to start coming through the letter box!

What next? 'Inside Out' is 10 years old this year! Just after having my ileostomy operation in 1999, I can remember Clare Bossom asking me if I would be interested in the formation of a stoma support group; I said 'yes' and have been a (paid up) member ever since!

To celebrate our 10th birthday we are going to have a 'dinner' at a local venue, with the manufacturers displaying their wares. This will probably be around September time, but nothing has been decided yet. Cost approximately £20 - £25.00 per person. This will replace the usual 'Open Day' and AGM in June. The AGM will be a very quiet affair this year but should be back to normal in 2010.

Your committee hope that you will support our birthday celebration dinner, we will give you the date and all relevant information as soon as we know it ourselves.

I hope that 2009 is a really good year for you all. I wish everyone all best wishes and good health.

Secretary/Treasurer

Inside Out

Coffee Mornings

In the Out Patients department of St Marks, Level 3
10.00am - 12.00pm

We are there to enable you to seek advice about your stoma, or if you just want a chat and a cup of tea or coffee then you are more than welcome. We are fortunate to have visits from manufacturers at some Coffee Mornings – please see below. This is an excellent way of viewing the latest products and/or simply chat to the experts.

March	Friday 6th	Fittleworth
	Monday 16th	
	Tuesday 31st	CUI Wear
April	Wednesday 15th	Coloplast
	Thursday 30th	OstoMart

Our outpatient clinic offers:

- Ongoing support to all ostomists
- Practical help and advice
- Colostomy irrigation information, advice and teaching
- Support garment measuring service
- Up to date information
- Psychological and sexual advice
- Support group information and networking

Transport

If you require transport for the stoma outpatient clinic, you will need to contact your G.P., who will be able to provide this for your initial session. In future, if you require transport and meet the criteria, a voluntary service may be provided. There may be a small charge for this if you do not live within the voluntary perimeters.

Where to find us

St Mark's Entrance:

On entering St Mark's Hospital, level 3, turn left and walk past reception. Go through the double doors and The St. Mark's Tea Bar will be in front of you. Turn right and you can either take the stairs or the lift to level 4. If you take the stairs, when you are on level 4 you will need to turn right, if via the lift left and go through the double doors in front of you, and turn left. In front will be a sign above the doors 'Intestinal Imaging Centre. Diagnostic Radiology. Physiology. Pouch Team/Stoma Care. Go to reception and announce yourself and the stoma nurse will be informed that you have arrived.

Northwick Park Entrance:

Once you arrive at the main entrance of Northwick Park, follow the signs for St Mark's Hospital. There is a link corridor between Northwick Park Hospital and St Mark's Hospital on level 4. Follow the link corridor to the end and on the left will be the Intestinal Imaging Centre. Diagnostic Radiology. Physiology. Pouch Team/Stoma Care. Go to reception and announce yourself and the stoma nurse will be informed that you have arrived.

Sarah Varma
Specialist Stoma Care Nurse

programme from the retrospective arm and the prospective arm and this should re-enforce the use of the programme in prevention of parastomal hernia.
In conclusion it is vital that prevention strategies are a significant aspect of a stoma care nurses role to provide care and advice in prevention of parastomal hernias as the age old saying states "Prevention is always better than cure".

If any member wishes to read the complete paper please contact Bob by phone or email. CD

Attention! Important! Please Read:

Whilst every care has been taken to ensure that the information in this publication is accurate and complete, the contents of this newsletter are provided for general information only and should not be relied upon for any specific purpose. Inside Out Stoma Group accepts no responsibility for the accuracy or statements made. Anyone acting upon them does so entirely at their own risk. We recommend that you consult your stoma nurse or doctor before changing your procedures.

The Northwick Park and St Mark's Stoma Care Service

The overall aim of the stoma care service is to provide an informative and supportive service to our patients. This will commence when you meet your stoma care nurse, usually prior to surgery. You will be given information and booklets regarding stomas and stoma surgery. On admission to hospital your stoma care nurse will reinforce this information and discuss any concerns and anxieties you may have. Following your operation, you will be shown how to care for your stoma. This involves learning to empty and change the stoma appliance independently, information regarding your diet, ongoing supplies, returning to work, common problems and much more will also be given. If you are a local patient then you will be followed up in the stoma clinic two weeks after discharge. If you live outside the area then you will be referred to a stoma care nurse based in your area who will provide ongoing support. Our services also include educating other health care professionals, such as ward nurses and district nurses which leads to patients with stomas receiving continuous care from all. Other areas that we are involved in are research and development of new appliances, assisting patients support groups and presenting at national and international conferences.

The Northwick Park and St. Mark's Stoma Care Clinic

The Northwick Park Hospital and St. Mark's Stoma Care clinics are for patients to attend for routine checkups, if problems occur or if further information is required. These are run on alternative Tuesday and Wednesday afternoons between 1.30pm and 3.30pm and Thursday mornings between 10am and 12.30pm. All local patients will receive a follow up appointment with a stoma nurse via the post for a two week follow-up after discharge. This appointment is part of your ongoing care and treatment and it is expected that you will attend.

The clinic is appointment based only and appointments can be made by contacting the department directly on 020 8235 4110. You may get an answering machine when you call, if so, please leave a message along with a contact number. Also referrals can be made via your GP.

Bob, our Chair has received an excellent, very informative paper from Mary Jo Thompson RGN ENB 216 BSc (Hons) PGDip Advanced Nursing MSc and Bernie Trainor on Parastomal hernia: Incidence, prevention and treatments. Unfortunately, it is too lengthy for our newsletter but I have Mary Jo's permission to extract those sections which will be informative and therefore of value to our members and I have pleasure in reproducing them here for your information.

Parastomal Hernia: Incidence, prevention and treatments

Abstract
Parastomal hernia continues to be a common and distressing problem for patients with stomas and research investigating prevention strategies is scant. In March 2005 Thompson and Trainor reported the introduction of a prevention programme for 1-year post stoma surgery formation had significantly reduced the incidence of development of parastomal hernia. This was further supported by a follow-up study in 2007 strengthening the reliability and validity of the first findings by confirming a statistically significant reduction in the incidence of parastomal hernias through the introduction of a simple non-invasive prevention programme. This extract reviews the current literature on incidence, prevention and general advice to help minimize the risk of parastomal hernia development following surgery.

Introduction
Parastomal hernia is a frequent difficulty for patients who have stomas affecting body image and self-confidence and accounts for approximately 20-50% of patients (Williams, 2003; Raymond & Abulafi, 2002). When a stoma is formed for whatever reason a potential site of weakness is created within the abdominal muscle due to the surgical dissection of muscle to externalise the bowel. Rolstad and Boarini (1996) define a parastomal hernia as a bulging of peristomal skin indicating the passage of one or more loops of bowel through a fascial defect around the stoma and into the subcutaneous tissues. This presents problems for the patient in terms of self-image due to a visible swelling in clothing, as well as practical appliance management difficulties.

Incidence
Incidence may be higher than reported in the literature as limited studies are available. Of those available, incidence varies (see table 1).

Table 1. Reported incidence of parastomal hernia development

Incidence of parastomal hernia	Studies
7%	Harris et al (2003)
16%	Lala et al (2002), Arumugam et al (2003)
20%	Pringle and Swan (2001)
28%	Thompson & Trainor (2005)
10-50%	Raymond & Abulafi (2002)

Limitations of those studies explored were use of small samples, inconsistencies in follow-up and timing of development of parastomal hernia and these factors ultimately hinder comparability. A review of the literature revealed little research into prevention of parastomal hernia. An article which reviewed the available literature related to prevention, treatment and incidence of parastomal hernia was uncovered (McGrath et al, 2006).

Contributing factors
Contributing factors to the incidence of a parastomal hernia differs from study to study with some reporting factors such as obesity, sex, age, siting of stoma, abdominal distension and chronic cough (Pearl, 1989; McGrath et al, 2006)). Bucknall et al (1982) found a statistically significant correlation between wound herniation and the elderly, males and obese patients undergoing bowel surgery. Bucknall and Ellis (1984) supported this finding by its report that chest infection, wound sepsis, male and aged 60+ were contributing factors. The correlation with age can be explained by the fact that, with increasing age, the rectus abdominus muscle becomes thinner and weaker and is thus hindered in providing adequate support for a stoma (Williams 2003).

Thompson and Trainor (2005, 2007) found statistically significant differences with age in both studies re-enforcing Bucknall et al (1982) and Bucknall and Ellis (1984).
Carne et al (2003) when they found no technical factors relating to the construction of the stoma were shown to prevent stoma herniation e.g. site of stoma formation, trephine size, fascial fixation and closure of lateral space. Thompson and Trainor (2005, 2007) also found no difference in incidence of parastomal hernia development when stomas were sited pre-operatively. Yet an earlier study by Sjodahl et al (1988) found that stomas constructed through the rectus abdominus muscle had a statistically significantly lower incidence than those constructed lateral to the rectus abdominus muscle with incidences of 2.9% and 21.6% respectively. A limitation to this study is the omission of length of time lapsed from surgery to follow-up. Martin and Foster (1996) would support this finding as they found that making an oversized opening for the stoma in the muscle and fascia at time of surgery as a possible cause of parastomal hernia (Kane et al, 2004). It is also important to point out that most stomas in recent years whether constructed with or without siting would in the majority if not all cases be constructed through the rectus abdominus muscle as this is taken as common practice.

Prevention
Thompson & Trainor (2005) and (2007) investigated the use of a prevention programme which utilised 3 components:

– Awareness of potential for development of parastomal hernia
– abdominal exercises to strengthen the abdominal muscles and
– utilising abdominal support belts whilst undertaking heavy lifting and heavy work for 1 year post-operatively

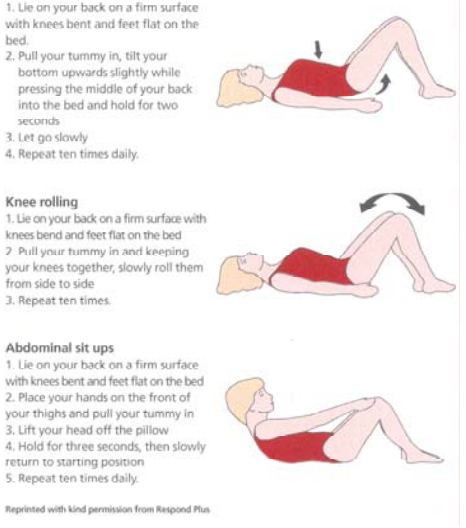
The findings demonstrated a statistically significant reduction in the incidence of parastomal hernias from 28% to 14% to 17% (years 1, 2 and 3 respectively). These exercises were used by physiotherapists whilst teaching patients after major abdominal and gynaecological surgery and can be recommended post-operatively or when the abdominal wound has healed for all patients who have undergone stoma forming surgery. The findings suggested that siting of stomas, type of surgery (emergency or elective) did not have any significance in the development of parastomal hernia.
Overall incidence of parastomal hernia in Year 1 was 28% (n=24) which is similar to the reported incidence within the literature. In Year 2 following the introduction of the programme the incidence had dropped to 14% (n=16). Chi square demonstrated significance, (p 0.025) suggesting the introduction of the programme had a statistically significant effect in reducing the incidence of development of parastomal hernias.
When year 1 and year 3 were tested Chi square did not demonstrate statistical significance, which suggested unreliability of the results from the first study. However on closer examination, in year 3 compliance had been inquired after from patients at each review appointment and 7 of these patients reported they had not complied with the prevention programme. When these revised figures for those following the programme (n=10) were analysed using Chi square statistical significance was found ($p \leq 0.01$). This finding thus re-enforces the use of this programme in the prevention of parastomal hernia, and would demonstrate reliability of the programme.
From these studies general advice has been compiled for patients to help minimise the risk of development of parastomal hernia (see table 2).

Table 2: General advice to help minimise the risk of parastomal hernia development following surgery

Strong abdominal muscles are the premise for this prevention programme and any general exercise which uses these muscles is beneficial (eg: swimming, walking and cycling). Please check with your surgeon or stoma care nurse before undertaking any exercise programme.

1. Avoid heavy lifting for 3 months post surgery
2. Try to maintain good posture at all times
3. Carry out the exercises below from as early as discharge if the wound has completely healed
4. Use a support belt or girdle when undertaking heavy lifting or heavy working after 3 months and until at least 12 months post-operatively
5. Keep your weight within the BMI (Body mass index) 20-25
6. Support your stoma and abdomen whilst coughing in the first few months following surgery.

Figure 1 Abdominal exercises following stoma forming surgery



(Taken from Thompson, M.J. Trainor, B. (2007) Prevention of parastomal hernia: a comparison of results 3 months on IN Gastro-intestinal Nursing Journal 5(3):22-28

Treatment
Treatments for parastomal hernia can be conservative or surgical. When treating conservatively reassurance for the patient (Kane et al, 2004; Blackley, 1998) is fundamental as it can be frightening and distressing. Correctly fitting flexible appliances (Kane et al, 2004; Armstrong, 2001) allow mouldability to the peristomal skin ensuring a secure and comfortable fit. Abdominal support belts or girdles can be recommended to provide comfort and support for the patient and caution should be stressed to the patient in relation to heavy lifting and heavy work (Kane et al, 2004; McCahon, 1999) to prevent or minimise further enlargement of the parastomal hernia. Patients should be encouraged to exercise their abdominal muscles to strengthen them however surgical permission should be sought prior to this if a hernia is already present. A BMI range of between 20-25 should be strived for and regular exercise should be encouraged.

Surgical repair of parastomal hernia can be carried out locally but this has a high recurrence rate (Everingham, 1998; Baig et al, 2003). Relocation of the stoma with or without using a synthetic mesh (Raymond and Abulafi, 2002) is another option which has a more favourable outcome. Several new repair methods have been investigated with Raymond and Abulafi (2002) used a split mesh technique (n=3) and all remained recurrence-free between 18 and 24 months. The repair of parastomal hernias is frequently found to be unsuccessful and often has complications. Stoma relocation is a method of choice for a first parastomal hernia. For recurrence, repair using prosthetic material appears to have the best outcomes (Rubin, 2004).

Conclusion
Parastomal hernia presents significant morbidity for patients requiring stoma-forming surgery and should be highlighted at pre-operative consultations where and when possible as its incidence presents significant risk for patients. Further research into prevention of parastomal hernia needs to be undertaken along with replication of the studies which have tried new methods of repairing parastomal hernias.
It is important to remember that surgical technique plays an important factor and will differ from centre to centre; this is clearly demonstrated by the literature on incidence of hernia. If centres do adopt a prevention programme what should not differ is the % of reduction following the introduction of the